

UNITED STATES BANKRUPTCY COURT  
NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

IN RE: :  
: CHAPTER 11  
SUPERIOR HEALTHCARE INVESTORS, INC., :  
: Case No. 15-50439-pwb  
Debtor :  
\_\_\_\_\_ :

DEBTOR'S STANDARD MONTHLY OPERATING REPORT (BUSINESS)

FOR THE PERIOD  
FROM 7/1/15 TO 7/31/15

Comes now the above-named debtor and files its Monthly Operating Reports in accordance with the Guidelines established by the United States Trustee and FRBP 2015.

/s/ G. Frank Nason, IV  
Attorney for Debtor's Signature

Debtor's Address  
and Phone Number:

c/o AltaCare Corporation  
3050 Royal Blvd  
Suite 190  
Alpharetta, GA 30022  
(770) 870-2813

Attorney's Address  
and Phone Number:

G. Frank Nason, IV  
Lamberth, Cifelli, Ellis & Nason, P.A.  
3343 Peachtree Rd, Suite 550  
Atlanta, GA 30326  
(404) 262-7373

Note: The original Monthly Operating Report is to be filed with the court and a copy simultaneously provided to the United States Trustee Office. Monthly Operating Reports must be filed by the 20<sup>th</sup> day of the following month.

For assistance in preparing the Monthly Operating Report, refer to the following resources on the United States Trustee Program Website, [http://www.usdoj.gov/ust/r21/reg\\_info.htm](http://www.usdoj.gov/ust/r21/reg_info.htm)

**SCHEDULE OF RECEIPTS AND DISBURSEMENTS**  
**FOR THE PERIOD BEGINNING 7/1/2015 AND ENDING 7/31/2015**

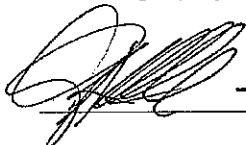
Name of Debtor: Superior Healthcare Investors, Inc. Case Number 15-50439-PWB

Date of Petition: 1/6/2015

	<u>CURRENT MONTH</u>	<u>CUMULATIVE PETITION TO DATE</u>
<b>1. FUNDS AT BEGINNING OF PERIOD</b>	<u>0.00</u> (a)	<u>0.00</u> (b)
<b>2. RECEIPTS:</b>		
A. Cash Sales	<u>0.00</u>	<u>0.00</u>
Minus: Cash Refunds	<u>(-)</u>	
Net Cash Sales		
B. Accounts Receivable		
C. Other Receipts (See MOR-3)	<u>2,000,000.00<sup>1</sup></u>	<u>2,000,000.00</u>
(If you receive rental income, you must attach a rent roll.)		
<b>3. TOTAL RECEIPTS (Lines 2A+2B+2C)</b>	<u>2,000,000.00</u>	<u>2,000,000.00</u>
<b>4. TOTAL FUNDS AVAILABLE FOR     OPERATIONS (Line 1 + Line 3)</b>	<u>2,000,000.00</u>	<u>2,000,000.00</u>
<b>5. DISBURSEMENTS</b>		
A. Advertising		
B. Bank Charges		
C. Contract Labor		
D. Fixed Asset Payments (not incl. in "N")		
E. Insurance		
F. Inventory Payments (See Attach. 2)		
G. Leases		
H. Manufacturing Supplies		
I. Office Supplies		
J. Payroll - Net (See Attachment 4B)		
K. Professional Fees (Accounting & Legal)		
L. Rent		
M. Repairs & Maintenance		
N. Secured Creditor Payments (See Attach. 2)		
O. Taxes Paid - Payroll (See Attachment 4C)		
P. Taxes Paid - Sales & Use (See Attachment 4C)		
Q. Taxes Paid - Other (See Attachment 4C)		
R. Telephone		
S. Travel & Entertainment		
Y. U.S. Trustee Quarterly Fees		
U. Utilities		
V. Vehicle Expenses	<u>586,448.07</u>	<u>586,448.07</u>
W. Other Operating Expenses (See MOR-3)		
<b>6. TOTAL DISBURSEMENTS (Sum of 5A thru W)</b>	<u>586,448.07</u>	<u>586,448.07</u>
<b>7. ENDING BALANCE (Line 4 Minus Line 6)</b>	<u>1,413,551.93(c)</u>	<u>1,413,551.93 (c)</u>

I declare under penalty of perjury that this statement and the accompanying documents and reports are true and correct to the best of my knowledge and belief.

This 13th day of Oct, 2015.

 (Signature)

<sup>1</sup> Allocated portion of sale price for operating facility. Proceeds held in trust with counsel for joint debtor, HP/Superior, Inc.

**MONTHLY SCHEDULE OF RECEIPTS AND DISBURSEMENTS (cont'd)**

**Detail of Other Receipts and Other Disbursements**

**OTHER RECEIPTS:**

Describe Each Item of Other Receipt and List Amount of Receipt. Write totals on Page MOR-2, Line 2C.

<u>Description</u>	<u>Current Month</u>	<u>Cumulative Petition to Date</u>
<u>Allocated Portion of Sale Proceeds</u>	<u>2,000,000.00</u>	<u>2,000,000.00</u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u>TOTAL OTHER RECEIPTS</u>	<u>2,000,000.00</u>	<u>2,000,000.00</u>

**"Other Receipts" includes Loans from Insiders and other sources (i.e. Officer/Owner, related parties directors, related corporations, etc.). Please describe below:**

<u>Loan Amount</u>	<u>Source of Funds</u>	<u>Purpose</u>	<u>Repayment Schedule</u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

**OTHER DISBURSEMENTS:**

Describe Each Item of Other Disbursement and List Amount of Disbursement. Write totals on Page MOR-2, Line 5W.

<u>Description</u>	<u>Current Month</u>	<u>Cumulative Petition to Date</u>
<u>Douglas County Treasurer Prior Year Taxes</u>	<u>531,755.84</u>	<u>531,755.84</u>
<u>Douglas County personal Property Taxes</u>	<u>20,491.20</u>	<u>20,491.20</u>
<u>Douglas County Treasurer 2015 taxes</u>	<u>34,201.03</u>	<u>34,201.03</u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u>TOTAL OTHER DISBURSEMENTS</u>	<u>586,448.07</u>	<u>586,448.07</u>

**NOTE: Attach a current Balance Sheet and Income (Profit & Loss) Statement.**

**ATTACHMENT 1**

**MONTHLY ACCOUNTS RECEIVABLE RECONCILIATION AND AGING**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

ACCOUNTS RECEIVABLE AT PETITION DATE: None

Note: There is unpaid rent and expenses due prepetition from related administratively consolidated debtor HP/Superior, Inc., but no receivables in the traditional sense.

**ACCOUNTS RECEIVABLE RECONCILIATION**

(Include all accounts receivable, pre-petition and post-petition, including charge card sales which have not been received):

Beginning of Month Balance	\$ _____ (a)
PLUS: Current Month New Billings	
MINUS: Collection During the Month	\$ _____ (b)
PLUS/MINUS: Adjustments or Writeoffs	\$ _____ *
End of Month Balance	\$ _____ (c)

\*For any adjustments or Write-offs provide explanation and supporting documentation, if applicable:

**POST PETITION ACCOUNTS RECEIVABLE AGING**

(Show the total for each aging category for all accounts receivable)

0-30 Days	31-60 Days	61-90 Days	Over 90Days	Total
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____ (c)

For any receivables in the "Over 90 Days" category, please provide the following:

<u>Customer</u>	<u>Receivable Date</u>	<u>Status</u> (Collection efforts taken, estimate of collectibility, write-off, disputed account, etc.)
_____	_____	
_____	_____	
_____	_____	
_____	_____	

**MONTHLY ACCOUNTS PAYABLE AND SECURED PAYMENTS REPORT**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

In the space below list all invoices or bills incurred and not paid since the filing of the petition. Do not include amounts owed prior to filing the petition. In the alternative, a computer generated list of payables may be attached provided all information requested below is included.

**POST-PETITION ACCOUNTS PAYABLE**

<u>Date Incurred</u>	<u>Days Outstanding</u>	<u>Vendor</u>	<u>Description</u>	<u>Amount</u>
			None	
TOTAL AMOUNT				

(b)

☐ Check here if pre-petition debts have been paid. Attach an explanation and copies of supporting documentation.

**ACCOUNTS PAYABLE RECONCILIATION (Post Petition Unsecured Debt Only)**

Opening Balance	\$ None	(a)
PLUS: New Indebtedness Incurred This Month	\$	
MINUS: Amount Paid on Post Petition, Accounts Payable This Month	\$	
PLUS/MINUS: Adjustments	\$	*
Ending Month Balance	\$	(c)

\*For any adjustments provide explanation and supporting documentation, if applicable.

**SECURED PAYMENTS REPORT**

List the status of Payments to Secured Creditors and Lessors (Post Petition Only). If you have entered into a modification agreement with a secured creditor/lessor, consult with your attorney and the United States Trustee Program prior to completing this section).

<u>Secured Creditor/ Lessor</u>	<u>Date Payment Due This Month</u>	<u>Amount Paid This Month</u>	<u>Number of Post Petition Payments Delinquent</u>	<u>Total Amount of Post Petition Payments Delinquent</u>
TOTAL			(d)	

**INVENTORY AND FIXED ASSETS REPORT**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015

Period ending 7/31/2015

**INVENTORY REPORT**

INVENTORY BALANCE AT PETITION DATE: \$ None

**INVENTORY RECONCILIATION:**

Inventory Balance at Beginning of Month	\$	_____ (a)
PLUS: Inventory Purchased During Month	\$	_____
MINUS: Inventory Used or Sold	\$	_____
PLUS/MINUS: Adjustments or Write-downs	\$	_____ *
Inventory on Hand at End of Month	\$	_____

**METHOD OF COSTING INVENTORY:**

\*For any adjustments or write-downs provide explanation and supporting documentation, if applicable.

**INVENTORY AGING**

Less than 6 months old	6 months to 2 years old	Greater than 2 years old	Considered Obsolete	Total Inventory
_____ %	_____ %	_____ %	_____ %	= _____ 100%*

\* Aging Percentages must equal 100%.

☐ Check here if inventory contains perishable items.

**Description of Obsolete Inventory:**

**FIXED ASSET REPORT**

FIXED ASSETS FAIR MARKET VALUE AT PETITION DATE: \$2,400,000 (b)  
(Includes Property, Plant and Equipment)

BRIEF DESCRIPTION (First Report Only): Real Property at 1800 New York Avenue, Superior, WI 54880

**FIXED ASSETS RECONCILIATION:**

Fixed Asset Book Value at Beginning of Month	\$	_____ (a)(b)
MINUS: Depreciation Expense	\$	_____
PLUS: New Purchases	\$	_____
PLUS/MINUS: Adjustments or Write-downs	\$	_____ *
Ending Monthly Balance	\$	_____

\*For any adjustments or write-downs, provide explanation and supporting documentation, if applicable.

BRIEF DESCRIPTION OF FIXED ASSETS PURCHASED OR DISPOSED OF DURING THE REPORTING PERIOD: Facility Sold

**ATTACHMENT 4A**

**MONTHLY SUMMARY OF BANK ACTIVITY - OPERATING ACCOUNT**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

Attach a copy of current month bank statement and bank reconciliation to this Summary of Bank Activity. A standard bank reconciliation form can be found at [http://www.usdoj.gov/ust/r21/reg\\_info.htm](http://www.usdoj.gov/ust/r21/reg_info.htm). If bank accounts other than the three required by the United States Trustee Program are necessary, permission must be obtained from the United States Trustee prior to opening the accounts. Additionally, use of less than the three required bank accounts must be approved by the United States Trustee.

NAME OF BANK: Nat'l Bank of Commerce BRANCH:

ACCOUNT NAME: HP Superior Deposits ACCOUNT NUMBER: xxxx2463

PURPOSE OF ACCOUNT: Collection and Remittance of HP Superior Receivables

Description: Although this account is in the name of Superior Healthcare Investors, Inc. ("SHI"), all funds collected are property of related debtor HP/Superior, Inc. ("HP"), and are treated as collections of HP and are transferred to HP. The collections are not disbursed by SHI to any entity other than HP, and such intercompany transfers are not treated as disbursements..

**CHECK REGISTER - OPERATING ACCOUNT**

Name of Debtor: Superior Healthcare Investors, Inc.

Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015

Period ending 7/31/2015

NAME OF BANK: Nat'l Bank of Commerce BRANCH:

ACCOUNT NAME: HP Superior Deposits

ACCOUNT NUMBER: xxxx2463

PURPOSE OF ACCOUNT: Collection and Remittance of HP Superior Receivables

Account for all disbursements, including voids, lost checks, stop payments, etc. In the alternative, a computer generated check register can be attached to this report, provided all the information requested below is included.

<u>DATE</u>	<u>CHECK NUMBER</u>	<u>PAYEE</u>	<u>PURPOSE</u>	<u>AMOUNT</u>
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
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_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		

TOTAL

159





**National Bank**  
of Commerce

PO Box 99  
1127 Tower Avenue  
Superior, WI 54880  
715.394.5531

nbcbanking.com

Member FDIC

4232 1 SP 0.485

Date 7/31/15 Page 1  
Primary Account Ending 2463  
Enclosures

C 16  
S 4232

SUPERIOR HEALTHCARE INVESTORS INC  
3050 ROYAL L BLVD SOUTH  
SUITE 190  
ALPHARETTA GA 30022



\* \* \* CHECKING ACCOUNTS \* \* \*

Account Title: SUPERIOR HEALTHCARE INVESTORS INC

WE ARE TAKING PRECAUTIONS TO PROTECT OUR DEBIT CARD CUSTOMERS FROM FRAUDULENT TRANSACTIONS. BEFORE YOU TRAVEL, PLEASE NOTIFY US.

BUSINESS CHECKING		Number of Enclosures	0
Account Number	Ending 2463	Statement Dates	7/01/15 thru 8/02/15
Previous Balance	142.37	Days in the statement period	33
2 Deposits/Credits	32,414.25	Average Ledger	1,116.04
2 Checks/Debits	32,412.00	Average Collected	1,116.04
SERVICE CHARGE	.00		
Interest Paid	.00		
Current Balance	144.62		

DESCRIPTIVE CREDITS AND DEBITS

7/01 Analysis Service Charge	12.00-	130.37
7/23 PRV PYMTSF WPS - WISCONSIN	32,406.90	32,537.27
ST FRANCIS IN THE PARK		
03037709054880		
TRN*1*2015072110400202*1391268		
299\		
7/24 TRANSFER PER JEN ROSE	32,400.00-	137.27
7/27 PRV PYMTSF CCCW - WPSHI	7.35	144.62
ST FRANCIS IN THE PARK		
03037709054880		
TRN*1*2015072310600336*1391268		
299\		

## RECONCILIATION INSTRUCTIONS

## Date \_\_\_\_\_

18312



Date 7/31/15 Page 2  
Primary Account Ending 2463  
Enclosures

C 18  
S 4232

BUSINESS CHECKING Ending 2463 (Continued)

* * * DAILY BALANCE INFORMATION * * *			
Date	Balance	Date	Balance
7/01	130.37	7/24	137.27
7/23	32,537.27	7/27	144.62



Date 8/31/15 Page 1  
Primary Account @XXXXXXXXXXXX@2463  
Enclosures

SUPERIOR HEALTHCARE INVESTORS INC  
3050 ROYAL L BLVD SOUTH  
SUITE 190  
ALPHARETTA GA 30022

\* \* \* CHECKING ACCOUNTS \* \* \*

Account Title: SUPERIOR HEALTHCARE INVESTORS INC

WE ARE TAKING PRECAUTIONS TO PROTECT OUR DEBIT CARD CUSTOMERS FROM FRAUDULENT  
TRANSACTIONS. BEFORE YOU TRAVEL, PLEASE NOTIFY US.

BUSINESS CHECKING		Number of Enclosures	0
Account Number	@XXXXXXXXXXXX@2463	Statement Dates	8/03/15 thru 8/31/15
Previous Balance	144.62	Days in the statement period	29
1 Deposits/Credits	4,744.48	Average Ledger	3,768.86
3 Checks/Debits	4,542.00	Average Collected	3,768.86
SERVICE CHARGE	.00		
Interest Paid	.00		
Current Balance	347.10		

DESCRIPTIVE CREDITS AND DEBITS

8/03 Analysis Service Charge	12.00-	132.62
8/05 PRV PYMTSF WPS - WISCONSIN	4,744.48	4,877.10
ST FRANCIS IN THE PARK		
03037709054880		
TRN*1*2015080310200357*1391268		
299		
8/27 Wire Transfer Fee	30.00-	4,847.10
8/27 Wire Transfer Debit	4,500.00-	347.10
HP SUPERIOR INC		
071025661		
4814771037		
ST FRANCIS IN THE PARK		
1800 NEW YORK AVE		

Date 8/31/15 Page 2  
Primary Account @XXXXXXXXXX@2463  
Enclosures

BUSINESS CHECKING @XXXXXXXXXX@2463 (Continued)

DESCRIPTIVE CREDITS AND DEBITS

SUPERIOR 54880  
BMO HARRIS  
20150827 000005

* * * DAILY BALANCE INFORMATION * * *					
Date	Balance	Date	Balance	Date	Balance
8/03	132.62	8/05	4,877.10	8/27	347.10

**MONTHLY SUMMARY OF BANK ACTIVITY - PAYROLL ACCOUNT**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

Attach a copy of current month bank statement and bank reconciliation to this Summary of Bank Activity.  
A standard bank reconciliation form can be found at [http://www.usdoj.gov/ust/r21/reg\\_info.htm](http://www.usdoj.gov/ust/r21/reg_info.htm).

NAME OF BANK: None BRANCH:

ACCOUNT NAME: \_\_\_\_\_ ACCOUNT NUMBER:

PURPOSE OF ACCOUNT: PAYROLL

Ending Balance per Bank Statement	\$
Plus Total Amount of Outstanding Deposits	\$
Minus Total Amount of Outstanding Checks and other debits	\$ _____ *
Minus Service Charges	\$
Ending Balance per Check Register	\$ _____ **(a)

**\*Debit cards must not be issued on this account.**

**\*\*If Closing Balance is negative, provide explanation:**

The following disbursements were paid by Cash: ( ☐ Check here if cash disbursements were authorized by United States Trustee)

Date	Amount	Payee	Purpose	Reason for Cash Disbursement
_____	_____			
_____	_____			
_____	_____			

The following non-payroll disbursements were made from this account:

Date	Amount	Payee	Purpose	Reason for disbursement from this account
_____	_____			
_____	_____			
_____	_____			
_____	_____			

(a) The total of this line on Attachment 4A, 4B and 4C plus the total of 4D must equal the amount reported as

“Ending Balance” on Schedule of Receipts and Disbursements (Page MOR-2, Line 7).





**ATTACHMENT 4C**

**MONTHLY SUMMARY OF BANK ACTIVITY - TAX ACCOUNT**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

Attach a copy of current month bank statement and bank reconciliation to this Summary of Bank Activity. A standard bank reconciliation form can be found on the United States Trustee website, <http://www.usdoj.gov/ust/r21/index.htm>.

NAME OF BANK: None BRANCH:

ACCOUNT NAME: \_\_\_\_\_ ACCOUNT NUMBER:

PURPOSE OF ACCOUNT: TAX

Ending Balance per Bank Statement	\$	
Plus Total Amount of Outstanding Deposits	\$	
Minus Total Amount of Outstanding Checks and other debits	\$	*
Minus Service Charges	\$	
Ending Balance per Check Register	\$	** (a)

**\*Debit cards must not be issued on this account.**

**\*\*If Closing Balance is negative, provide explanation:**

The following disbursements were paid by Cash: ( ☐ Check here if cash disbursements were authorized by

Date	Amount	Payee	Purpose	Reason for Cash Disbursement
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

The following non-tax disbursements were made from this account:

Date	Amount	Payee	Purpose	Reason for disbursement from this account
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**ATTACHMENT 5C**

**CHECK REGISTER - TAX ACCOUNT**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

NAME OF BANK: None BRANCH:

ACCOUNT NAME: \_\_\_\_\_ ACCOUNT #

PURPOSE OF ACCOUNT: \_\_\_\_\_ TAX

Account for all disbursements, including voids, lost checks, stop payments, etc. In the alternative, a computer-generated check register can be attached to this report, provided all the information requested below is included.

<http://www.usdoj.gov/ust/>

CHECK				
<u>DATE</u>	<u>NUMBER</u>	<u>PAYEE</u>	<u>PURPOSE</u>	<u>AMOUNT</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

TOTAL \_\_\_\_\_(d)

**SUMMARY OF TAXES PAID**

Payroll Taxes Paid \_\_\_\_\_(a)  
Sales & Use Taxes Paid \_\_\_\_\_(b)  
Other Taxes Paid \_\_\_\_\_(c)  
TOTAL \_\_\_\_\_(d)

**ATTACHMENT 4D**

**INVESTMENT ACCOUNTS AND PETTY CASH REPORT**

**INVESTMENT ACCOUNTS**

Each savings and investment account, i.e. certificates of deposits, money market accounts, stocks and bonds, etc., should be listed separately. Attach copies of account statements.

Type of Negotiable

Instrument	Face Value	Purchase Price	Date of Purchase	Current Market Value
<u>None</u>				
<b>TOTAL</b>				_____ (a)

**PETTY CASH REPORT**

The following Petty Cash Drawers/Accounts are maintained:

	<b>(Column 2)</b> Maximum	<b>(Column 3)</b> Amount of Petty Cash On Hand (Column 2) and At End of Month	<b>(Column 4)</b> Difference between (Column 2) and (Column 3)
Location of Box/Account	Amount of Cash in Drawer/Acct.		
<u>None</u>			
<b>TOTAL</b>		<b>\$ _____ (b)</b>	

**For any Petty Cash Disbursements over \$100 per transaction, attach copies of receipts. If there are no receipts, provide an explanation**

**TOTAL INVESTMENT ACCOUNTS AND PETTY CASH(a + b) \$ \_\_\_\_\_  
(c)**

**ATTACHMENT 6**

**MONTHLY TAX REPORT**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

**TAXES OWED AND DUE**

Report all unpaid post-petition taxes including Federal and State withholding FICA, State sales tax, property tax, unemployment tax, State workmen's compensation, etc.

<b>Name of Taxing Authority</b>	<b>Date Payment Due</b>	<b>Description</b>	<b>Amount</b>	<b>Date Last Tax Return Filed</b>	<b>Tax Return Period</b>
<u>None<sup>2</sup></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<u></u>	<u></u>	<u></u>	<u></u>	<u></u>	
<b>TOTAL</b>			<b>\$ <u></u></b>		

<sup>2</sup> Property Taxes for 2015 relate to the first of the year and are treated as prepetition debts payable upon a sale of the facility.

**ATTACHMENT 7**

**SUMMARY OF OFFICER OR OWNER COMPENSATION**

**SUMMARY OF PERSONNEL AND INSURANCE COVERAGES**

Name of Debtor: Superior Healthcare Investors, Inc. Case Number: 15-50439-PWB

Reporting Period beginning 7/1/2015 Period ending 7/31/2015

Report all forms of compensation received by or paid on behalf of the Officer or Owner during the month. Include car allowances, payments to retirement plans, loan repayments, payments of Officer/Owner's personal expenses, insurance premium payments, etc. Do not include reimbursement for business expenses Officer or Owner incurred and for which detailed receipts are maintained in the accounting records.

<u>Name of Officer or Owner</u>	<u>Title</u>	<u>Payment Description</u>	<u>Amount Paid</u>
<u>Douglas K. Mittleider</u>	<u>President</u>	<u>None</u>	

**PERSONNEL REPORT**

	<u>Full Time</u>	<u>Part Time</u>
Number of employees at beginning of period	<u>1</u>	
Number hired during the period		
Number terminated or resigned during period		
Number of employees on payroll at end of period		

**CONFIRMATION OF INSURANCE**

List all policies of insurance in effect, including but not limited to workers' compensation, liability, fire, theft, comprehensive, vehicle, health and life. For the first report, attach a copy of the declaration sheet for each type of insurance. For subsequent reports, attach a certificate of insurance for any policy in which a change occurs during the month (new carrier, increased policy limits, renewal, etc.).

<u>Agent and/or Carrier</u>	<u>Phone Number</u>	<u>Policy Number</u>	<u>Coverage Type</u>	<u>Expiration Date</u>	<u>Date Premium Due</u>
<u>Affiliated FM Ins.</u>	<u>(404) 497-7500</u>	<u>GL967</u>	<u>Property</u>	<u>11/1/2015</u>	

**The following lapse in insurance coverage occurred this month:**

<u>Policy Type</u>	<u>Date Lapsed</u>	<u>Date Reinstated</u>	<u>Reason for Lapse</u>

           Check here if U. S. Trustee has been listed as Certificate Holder for all insurance policies.

**ATTACHMENT 8**

**SIGNIFICANT DEVELOPMENTS DURING REPORTING PERIOD**

Information to be provided on this page, includes, but is not limited to: (1) financial transactions that are not reported on this report, such as the sale of real estate (*attach closing statement*); (2) non-financial transactions, such as the substitution of assets or collateral; (3) modifications to loan agreements; (4) change in senior management, etc. Attach any relevant documents.

Facility Sold

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We anticipate filing a Plan of Reorganization and Disclosure Statement on or before \_\_\_\_\_